HIV Health Services Planning Council
Substance Use Prioritization Workgroup

eport

:	Members, HIV Health Services Planning Council
eting Date:	April 29, 1999
eting Place:	815 Buena Vista West
eting Time:	5:30 – 7:30 PM
mbers Present:	Don Bliss, Lisa O'Connor.
ers Present:	Celinda Cantu, David Macias, AIDS Office (AO); Julie Kawasaki, AIDS & Substance Abuse Program, UCSF/AHP; Michael Moors, minutes; Judith Stevensen, Baker Places.
t meeting:	Thursday, May 20, 1999, 815 Buena Vista West, 5:30 – 7:30 PM. Thursday, June 17, 1999, 815 Buena Vista West, 5:30 - 7:30 PM.

ARE Prioritization Overview/Consensus; Defining Severe Need; FY
sed strategies. [Attachment A]

nilies: *LO'C* discussed having more services for women with families has a children's program that's not being utilized. *Cilinda* thought critical an issue for this population as how they got infected with e's a need to find out if clients do not keep appointments due to lack reating new ways to provide child care such as having cooperative t primary care sites as well as SF General Hospital. *Celinda* noted ortation provider for women with families. *David* suggested meeting e treatment plan.

nda Cantu noted that over $88,000 in new harm reduction services AO implemented standardized objectives for process and outcome. sures should be seen this year. She suggested discussing principles conference on harm reduction in May.

nunity Services. *LO'C* said a gap exists between need and services in rely underserved category. She suggested Caucasians be linked in e since this entire category is underserved. *David* wondered who was risoners from one county's programs to another. *Julie* said that San tal Health Services (CMHS) often won't see prisoners from another

not all services in this sub-category get CARE funding. CMHS pays or basic treatment and the AO pays for counseling.

Services for Transgenders: *Celinda* said that the Tenderloin AIDS Resource Center is doing ransgender sensitivity training and there needs to be follow-up on the success of that program. *David* suggested that in some instances client grievances become in-house sensitivity trainings. *Celinda* said if the Council gives the AO a baseline for transgender services through process objectives they can establish a program.

Drop in center, with outpatient counseling: Action Point Centers came out of the Mayor's AIDS Summit last year. The AO will provide an update on this subject.

Hold harmless entire category: *Celinda* said that Substance Use providers were asked to do more than other category providers as far as integrating their services with those providers, she suggested other category providers be asked to connect with Substance Use. She pointed out that Residential, Methadone, and Detox are expensive services to provide.

HIV Health Services Planning Council
Substance Use Prioritization Workgroup

April Report
4/29/99

To: Members, HIV Health Services Planning Council
Meeting Date: April 29, 1999
Meeting Place: 815 Buena Vista West
Meeting Time: 5:30 – 7:30 PM

Members Present: Don Bliss, Lisa O'Connor.

Others Present: Celinda Cantu, David Macias, AIDS Office (AO); Julie Kawasaki, AIDS & Substance Abuse Program, UCSF/AHP; Michael Moors, minutes; Judith Stevensen, Baker Places.

Next meeting: Thursday, May 20, 1999, 815 Buena Vista West, 5:30 – 7:30 PM.
Thursday, June 17, 1999, 815 Buena Vista West, 5:30 - 7:30 PM.

LO'C distributed: FY 2000-01 CARE Prioritization Overview/Consensus; Defining Severe Need; FY 1999-00 Substance Abuse proposed strategies. [Attachment A]

- Services for Women with Families: *LO'C* discussed having more services for women with families and said that the Iris Center has a children's program that's not being utilized. *Cilinda* thought that substance use was not as critical an issue for this population as how they got infected with HIV. *David Macias* said there's a need to find out if clients do not keep appointments due to lack of child care and suggested creating new ways to provide child care such as having cooperative care using parents and staff at primary care sites as well as SF General Hospital. *Celinda* noted that Shanti is the main transportation provider for women with families. *David* suggested meeting service need through a service treatment plan.

- Harm Reduction model: *Celinda Cantu* noted that over $88,000 in new harm reduction services were instituted last year. The AO implemented standardized objectives for process and outcome. She said results of those measures should be seen this year. She suggested discussing principles and implementation after the conference on harm reduction in May.

- Links Between Jail and Community Services. *LO'C* said a gap exists between need and services in this area. and that it is a severely underserved category. She suggested Caucasians be linked in some way to the CBC initiative since this entire category is underserved. *David* wondered who was responsible for transferring prisoners from one county's programs to another. *Julie* said that San Francisco's Community Mental Health Services (CMHS) often won't see prisoners from another county.

- Methadone: *Celinda* said that not all services in this sub-category get CARE funding. CMHS pays for basic treatment and the AO pays for counseling.

- Services for Transgenders: *Celinda* said that the Tenderloin AIDS Resource Center is doing transgender sensitivity training and there needs to be follow-up on the success of that program. *David* suggested that in some instances client grievances become in-house sensitivity trainings. *Celinda* said if the Council gives the AO a baseline for transgender services through process objectives they can establish a program.

- Drop in center, with outpatient counseling: Action Point Centers came out of the Mayor's AIDS summit last year. The AO will provide an update on this subject.

- Hold harmless entire category: *Celinda* said that Substance Use providers were asked to do more than other category providers as far as integrating their services with those providers, she suggested other category providers be asked to connect with Substance Use. She pointed out that Residential, Methadone, and Detox are expensive services to provide.

- Use of alternative detox services: *Celinda* said acupuncture is often used for detox, and seems to help with HIV as well. She noted there are six bend dedicated to HIV+ detox clients at SFGH.

- Whole category: will get an update on integrated services from the AO.

DCB asked for utilization data. *Celinda* said it would be available toward the end of prioritization. The group voiced their concern at the loss of pharmacy services at SFGH. They agreed that the Primary Care Workgroup needs to hear that substance use patients having to wait six or more hours for medications at SFGH creates problems. They were also concerned about the loss of 4/P at SFGH.

Service Categories

Families
Incarcerated access to service
Transgender
Medical Detox beds

Proposed Programs

Childcare vouchers
Augment the CBC initiative
Evaluate services
Evaluate loss of bends and case management linked to them

Future presentations

Family Planning Council
Treatment on Demand/Integrated Committees
Action Point Centers
Update on SFGH pharmaceutical

All CARE Council & Committee meetings are held in accessible sites, and are open to members of the public. Participation of people living with HIV is strongly encouraged. Minutes of meetings and all information distributed to Council members are available for public inspection and copying. For further information contact Council staff at 415/554-9136.

Substance Abuse	Proposed FY 99-00 Allocation and Program Changes				
Sub-category	Proposed Strategies	Decreased funding	Level funding	Increased funding	Unexpended funds
Residential Long term	*Residential long and short-term: combine into variable length of stay services, with analysis of need, and limit based on utilization.*		=		
	More svcs for women with families (keeping children with them)		=		
	Training for providers on integrating harm reduction principles		=		X
	Better linkages of providers into networks of care.		=		
Residential Short term	Redirect some $ to a residential harm reduction model: change some program models in level funding, and create new program if additional funding		=	+	
	Stronger eval. of cultural competency, and training where needed.		=	+	X
	More links between jail and community svcs.		=	+	
	Services for MSM/IDUs			+	
	Furnishings for residential programs				X
Methadone	Hold harmless new programs: $75,000	-			
Outpatient Counseling	Develop programs as alternatives to drug use - recreational, etc. Especially for youth.			+	
	More services for transgender.			+	
	Media campaigns.				X
	Drop in center, with outpatient counseling			+	
	Childcare vouchers, linked to outpatient care.				X
	Hold harmless entire category.	-			
Detox	More use of alternative detox services, e.g. acupuncture.			+	
Whole Category	*Coordination of SA across funding streams: work with Treatment on Demand to leverage services, combine funding streams, and plan system as a whole. Link to housing and other services funded elsewhere (esp. youth services).*	-	=	+	
	Re-think category of substance abuse services, vs. services for substance abusers. Incorporate harm reduction principles across all services categories to make services more accessible to users.	-	=	+	

HIV Health Services Planning Council
Substance Use Prioritization

May Report

To: Members, HIV Health Services Planning Council
Meeting Date: May 20, 1999
Meeting Place: 815 Buena Vista West
Meeting Time: 5:30 – 7:00 PM

Members Present: Chair, Lisa O'Connor; Siddiq Jihad.

Others Present: Steve Anderson, Angela LaNorman, Waldon House HIV Services; Darrell Burton, Community Substance Abuse Services, Dept. of Public Health (DPH); David Macias, Laura Thomas, AIDS Office (AO); Mike Siever, Treatment on Demand Council (TODC).

Next meeting: Thursday, June 17, 1999, 25 Van Ness Ave, Rm. 330-A, 5:30 - 7:30 PM.

LO'C distributed: an agenda; FY 2000-01 CARE Prioritization Overview/Consensus; Defining Severe Need; FY 1999-00 Substance Abuse proposed strategies; the Council calendar for June. She noted two changes to the minutes of 4/29/99: Under Services for Women with Families, she said the discussion included integration of services. Under Links between Jail and Community Services, she said the Council should try to fund services to Caucasians similar to those provided through The Congressional Black Caucus initiative.

LO'C reviewed the prioritization documents and themes of the process.

Treatment-on-Demand
Mike Siever reviewed the priorities of the Treatment-On-Demand Council.

- Increased funding for methadone, which looks likely.
- Youth detox, may combine with residential and/or drop in center, he noted the difficulty of finding sites. The more programs can be combined the better the likelihood is they will succeed.
- Increased treatment in jails, he said there should be increased capacity to provide treatment for people who are incarcerated. A meeting is planned on June 3, 1999 to interview inmates.
- Outreach to lesbian, gay, bisexual, transgender and questioning youth.
- Medically supported detox which is threatened by the closure of SFGH 4/P. There has been discussion that 4/P will not close until there is a community based program to replace it, but it's unclear whether funds from the closure of 4/P will support the development of that program. Baker Place has limitations on what they can handle and is not set up to replace 4/P.

Mike said the mayor has put $1 million in the city budget for treatment-on-demand initiatives for the current year but is unwilling to increase the budgeted amount in coming years which makes it difficult to get the programs necessary to accomplish the priorities of the Treatment-on-Demand Council up and running. They plan to meet with the Board of Supervisors within the next month to state their case. He said there was an emphasis on harm reduction language included in the priorities. *LO'C* asked if there were statistics on what percentage of treatment-on-demand youth clients were HIV positive. *Mike* said they do not have that information currently but that the assumption was that a significant number of them were HIV positive. *LO'C* wondered how the CARE Council could work with the TODC to accomplish the stated priorities. *Laura* pointed out that the CARE Council suggested $75,000 in funding for new programs in methadone treatment be held harmless last year. *Darrell* said that money bought slots rather than going to a particular program. The slots went primarily to Ward 93.

Detox services:
There was discussion of funding for detox services and the closure of six beds in the Salvation Army program dedicated to HIV positive clients. *LO'C* said that more money was taken out the substance use category than was put back in last year. She wondered if the people currently in 4/P could be in another detox program or if they really need to be in a hospital setting. *Mike* said the likely consequence would be that those people would end up in the emergency room. *Laura* said the plan intended for people to continue to get services but to move them out of the hospital setting and

hopefully save money. *Mike* said the question is whether those people currently in 4/P can be adequately supported by community based detox. He was concerned that they will end up in the regular wards of SFGH. *Steve* said there is a definite need to continue 4/P so those clients that need a hospital setting have somewhere to go. He said people who don't need acute medical treatment are already being referred out of that setting to community based treatment. *Mike* said the patients in 4/P have significant psychiatric diagnosis in addition to their detox needs. *Darrell* said the plan to close 4/P needs to have a viable alternative in place before it can happen. *Mike* said Mitch Katz made the decision to close 4/P with no input from the DPH or community based detox programs. *Steve* said there is a gap in service after people are released from 4/P. *Laura* suggested a step down situation with the 6 bed 4/P facility for the most severe need, a 15 bed community based facility where patients could stay for one to two weeks after being released from 4/P. She pointed out that there are 2 beds in 4/P that are paid for with Title I dollars so the CARE Council has some leverage here. In the past the Council has said it wanted money to go to medical model detox. It is up to the AIDS Office to determine who should get that money. The Council can state that it wants to insure that the level of service remains the same which would mean there would need to be an equivalent level of support wherever the service is provided. *LO'C* said that in addition 4/P provides integrated services which are a priority of the Council. *Laura* said the Council could ask Jimmy Loyce for further information on that status of 4/P at the next Council meeting where he will be presenting the DPH master plan. The group agreed that the important point to stress is that, whether 4/P remains or not, the equivalent level of medical service is provided. *Laura* said that if 4/P closes that should translate to a greater number of beds in a community based facility. It was mentioned that there are no detox facilities in either Marin or San Mateo counties.

Methadone services:
Mike said methadone maintenance needs increased funding. *Darrell* said the State changed the method for reimbursement for methadone treatment, which makes it more difficult to get State funds. Doctors cannot yet prescribe methadone. There is a great need to increase methadone treatment capacity. *Laura* said the CARE Council has looked into methadone delivery for people with AIDS who are homebound. *SJ* said the CBC initiative was the first attempt to support the incarcerated with methadone treatment. He asked if the TODC has done a needs assessment and stressed the importance of getting accurate data to determine how CARE Council funds should be prioritized. *Mike* said the TODC has community meetings. *Darrell* said they are working toward a more formal structure for gathering data. *SJ* said he would make sure they get a copy of the CARE Council needs assessment.

Strength and weakness of Substance Use category
Residential (long & short term)
Strengths:
- On site services for mental health, substance abuse, case management, housing referrals. These are largely integrated or linked services.
- Adopting harm reduction principles.
- Accepted site for criminal justice system release.
- Treatment experience working with people with HIV/AIDS.

Weaknesses:
- Not serving jail population.
- No housing available after leaving program.
- Expensive.
- Access problem – limited availability.
- Cannot keep housing,
- Children not accepted to most programs.

Mike suggested producing a list of CARE funded long term residential sites.

Methadone
Strengths:
- Links to medical
- Maximized case management.
- Ward 93 well utilized.
- Integration of services.
- Accepted by treatment programs.

Weaknesses:
- Lack of access for uninsured. There's a need to help people determine if they are eligible for Medi-Cal.
- Lack of access to methadone in jail. Only Bayview provides after care for out patients.

- Limited space for expansion of Ward 93.

SJ suggested finding out the capacity of Ward 93.

Outpatient

Strengths:

- Gives clients a choice.
- People can keep children, housing, jobs.
- Utilizes more harm reduction and has established relapse policies.
- Low retention rates.

Weaknesses:

- Harder for homeless people to access.
- No childcare.
- No after-hours support for clients who need more structure.
- Lacking sensitivity to transgenders.
- Lacks links to 12 step programs.
- Need for mobile counselors.

Mike asked for a list of CARE funded providers in this category.

The group discussed the need to distinguish between outpatient and day treatment services. They felt there could be more CARE funded outpatient services.

Detox

Strengths:

- Low threshold for entry.
- Access to medical and mental health services.
- Referrals to housing or further treatment.
- Experience with HIV/AIDS medications.
- Cost efficient.

Weaknesses:

- No access for families and women/men with children.
- Does not serve jail population.
- Not enough capacity.
- Lack of housing.

Mike asked for a list of CARE funded providers in this category.

Wrap-up

LO'C said the focus of the next meeting would be to discuss the effects of level, increased, or decreased funding on the Substance Use category. She stressed the importance rating priorities so the AIDS Office can utilize unexpended funds promptly.

HIV HEALTH SERVICES PLANNING COUNCIL
SUBSTANCE USE PRIORITIZATION WORKGROUP

NEXT MTG THURSDAY, JUNE 17
AIDS OFFICE 25 VAN NESS AT
5:30 - 7:00 PM

AGENDA

MAY 20, 1999 5:30 - 7:00 PM

5:30 p.m. Introductions
Review/corrections of May minutes

5:45 p.m. Review prioritization documents
and themes of the process;
a) integration of services
b) outreach and information about existing services
c) outcomes/outcomes measures
also
1) access and capacity
2) utilization
3) quality

6:00 p.m. Treatment on demand priorities and progress at this point (Mike Shriver, Bernard or other T.O.D. member)

6:15 p.m. Strength and weakness of substance abuse category
a) what are the main strengths of this category?
b) what are the main weaknesses in this category
c) how well is the services in this category are doing re:
1) integration
2) outreach to marginalized populations
3) developing outcome measures
d) what recommendations do you want to make to improve services in this category?
(please note final draft recommendations for different levels of funding will be made in June meeting)

6:50 p.m. additional comments/Wrap-Up

Substance Abuse	Proposed FY 99-00 Allocation and Program Changes				
Sub-category	Proposed Strategies	Decreased funding	Level funding	Increased funding	Unexpended funds
Residential Long term	*Residential long and short-term: combine into variable length of stay services, with analysis of need, and limit based on utilization.*		=		
	More svcs for women with families (keeping children with them)		=		
	Training for providers on integrating harm reduction principles		=		X
	Better linkages of providers into networks of care.		=		
Residential Short term	Redirect some $ to a residential harm reduction model: change some program models in level funding, and create new program if additional funding		=	+	
	Stronger eval. of cultural competency, and training where needed.		=	+	X
	More links between jail and community svcs.		=	+	
	Services for MSM/IDUs			+	
	Furnishings for residential programs				X
Methadone	Hold harmless new programs: $75,000	-			
Outpatient Counseling	Develop programs as alternatives to drug use - recreational, etc. Especially for youth.			+	
	More services for transgender.			+	
	Media campaigns.				X
	Drop in center, with outpatient counseling			+	
	Childcare vouchers, linked to outpatient care.				X
	Hold harmless entire category.	-			
Detox	More use of alternative detox services, e.g. acupuncture.			+	
Whole Category	*Coordination of SA across funding streams: work with Treatment on Demand to leverage services, combine funding streams, and plan system as a whole. Link to housing and other services funded elsewhere (esp. youth services).*	-	=	+	
	Re-think category of substance abuse services, vs. services for substance abusers. Incorporate harm reduction principles across all services categories to make services more accessible to users.	-	=	+	

HIV Health Services Planning Council
Substance Use Prioritization

June Report I

To:	Members HIV Health Services Planning Council
Meeting Date:	June 17, 1999
Meeting Place:	25 Van Ness Ave., Room 330-B
Meeting Time:	5:30 PM to 7:15 PM
Members Present:	Lisa O'Connor; Co-chair, Diane Jones, Co-chair; Siddiq Jihad
Others Present:	Michael Siever, Treatment On Demand Council; David Macias, AIDS Office; Laura Thomas, AIDS Office; Robert Samson, minutes.
Next Meeting:	Wednesday, June 30, 1999, 25 Van Ness Ave., Room 330-B, 4-6 PM

Introduction/Review of May Meeting

SJ noted that a lot of his remarks from the previous meeting did not appear on the minutes. *RS* agreed to mention it to Michael Moors. *LO'C* presented the agenda and minutes from the May meeting (Attachment A.) The focus was setting prioritization for 2000-2002. There was also an attachment addressing underserved populations and barriers to service. *DM* expressed concern for how the term "need to" was used. He substituted "access." *DJ* Total client count around substance abuse by ethnicity is 5,200. Integrated model, which doesn't include substance abuse services, is 2,800. In majority of these integrated service models there is extremely high percentage of drug users who are accessing services. (26% African- American, 41% White, 100% Latino, 7% Asian.) *DM* asked for a clear definition of "integrated service model." DJ said it comprised six collaborations: TLC, API, Haight-Ashbury, Line-Martin, Native-American Health Center and St. Mary's/Shanti. *LO'C* remarked that there was so much data, even though it was limited in scope. *LT* said the 1999 numbers were only people diagnosed in the first three months. *MS* said these were only the diagnosed AIDS cases.

Discussion

DJ presented data on Residential Treatment, Methadone, Outpatient Counseling and Detox as well as data on Gender. Asked if there was another meeting scheduled. *LO'C* said one had not been scheduled. Focus of this meeting was to tie up this conversation, discuss integration and scenarios for increased funding. *DJ* remarked that the glitch was around Needs Assessment. Workgroups would schedule another meeting after June 28. Needs Assessment people will come to that meeting and present specific data relating to substance abuse. The workgroup shouldn't be coming up with recommendations in this meeting. *LO'C* said the workgroup has the priorities of the providers and needs to find out what the priorities of the consumers are. Perhaps the three scenarios should come in July. *DJ* asked where the Council is with linkage on Treatment On Demand. *MS* asked why the RFP was going out separately for a small amount of money when a larger chunk was to go out to create a community detox. *LT* said the Salvation Army didn't want to contract with the city anymore and turned the money back. CARE Council wanted to continue using that money for detox. *LO'C* The money was to go into existing models, but instead it went into RFP process. *LT* said the Council couldn't just hand money over to providers without an RFP. *MS* disagreed. Why wasn't it all coordinated? *LT* said she couldn't answer that. There is only so much she can do in talking to Russ. *DJ* reitcrated the need to discuss integration. Need to find ways of getting contracts integrated between CSAS and AIDS Office to avoid this kind of duplication. *MS* said eventually it's going to be PSAS doing this.

Integration

LO'C said the workgroup went over Treatment On Demand Priorities, and suggested reviewing the Integrated Meeting minutes. *DJ* asked what should be done with this opportunity. *LT* said there's limits on how much leverage she could have in terms of the plans that get made. *MS* said something needs to happen at DPH. *DJ* said the new detox RFP coming out of the AIDS Office is being done in isolation of the developing expansion of detox. *MS* said the process of creating a community based medically supported detox, the potential closing of 4P derailed 30-bed facility by CSAS. *DJ* said conversations need to take place to leverage each other's funding, support each other's services, and integrate these services whenever possible. *LT* said the question is, did Russ and Michelle talk to Jim and was a decision made to do this, or did this conversation never happen? *LO'C* said if there were an RFP for 30 beds the councils would really be working together. *MS* said the original plan for 4P was for 30 beds. *LO'C* suggested talking about integration. *MS* asked how this discussion integrated with the discussion on integrated services. *DJ* read her notes from the Integrated Services Meeting. Identified challenges to integration and gaps. Housing and access to housing remains the number one big gap. Mental health and substance abuse not well integrated. Mental health was not part of the integrated service delivery model. Communication issues between participating agencies, personnel and hiring issues as well as issues around computerization. The strengths of providing integrated services were: (1) one-stop shopping for referring clients, (2) accessing information for follow-up, and (3) onsite access to nursing mental health services. Integrated services were reaching people who hadn't previously been reached, particularly the mobile units. The integrated service model provided a safety net to catch people when they destabilize. There were greater options for accessing services at another site. The outcomes are hard to measure for this population. There is a need to redefine "outcome" away from the traditional meaning. *LO'C* said the use of incentives, such as vouchers, helped engage the clients. *DM* asked if outcomes are measured by fewer hospitalizations. *DJ* agreed. *LO'C* said for a population that doesn't access care a positive outcome might be increased use of services. *DJ* said the biggest weakness was that Substance Abuse was not part of the Integrated Model. Majority of money went to residential facilities. Should the Council be moving the money more toward Out Patient Services in order to serve a greater number of people? She asked about the relationship between substance abuse assessment and counseling. Existing funded services offer no options to people not interested in quitting. *DM* noted that this need had been addressed at New Leaf. *LO'C* stated that assessment is the key piece. *MS* agreed that the client needed to be part of the process. *LO'C* said that CARF is going to change things a lot. *DJ* asked if CSAS and the AIDS Office could allocate some of the Outpatient Counseling Money to create programs for people not interested in abstinence in order to have some alternatives to the current programs. Where are the real options, other than the Bridge Project in the Tenderloin? *LO'C* asked about legal services. *LT* talked about the way CSAS was managing the slots. *DJ* said that CSAS and the AIDS Office contract with community agencies but loses control of who has access. DPH has the pool of clients who need the services. *SJ* related that in 1997 the AIDS Office was doing a standardization of case management. The training was six months. All case managers had to participate. When it first started there were 70 people. I don't know what ever happened to that. There were 15 people at the end of it. There is a need to have standardization of harm reduction. It was a good conference, but there's no backup, nothing to lock that into place. In regards to AIDS Forensic, one of his case managers has been trying to call for the past two weeks, with nothing. No one else can do any training until they talk to them first. No one is holding them accountable, and here we are talking about allocating them $135,000. He expressed concern that there was no control once the money was moved out into the agencies. He applauded the Bridge Project in the Tenderloin for practicing harm reduction. The clients are drawn to them. Without standardization integration can't work. *LO'C* asked if the Bridge Project received CARE money. *SJ* replied that they only received SPINS money. This year their HRSA money runs out, and next year their HFA

money runs out. The Windsor Projeet has been held up for ninety days because they needed a director. They run on the same model as the Bridge Project. They're starting to delete positions from the Bridge Project, a Health Care Worker. He felt annoyed at things like that. *LO'C* asked MS for a report on his meeting in the jails. *MS* reported a laek of services for bi-lingual inmates. No housing and substance abuse treatment when they got out, as well as mental health. They expressed a need for linkage, so there is no diseonneet when they get out. There is no seamless transition from in jail to when they get out. *SJ* reiterated that there was no eonneetion. AIDS Forensie was not doing an exit plan. For HIV the elients are supposed to have a six-day packet, and that's not happening. If they don't have someone waiting for them at the door when they get out they aren't going to aceess substanee abuse. They'll be toxie in a couple of hours. *LT* talked about the issues of incareerated women: mental health serviees, post traumatie stress disorder, domestic violenee, sexual assault, as well as no serviees for bi-sexual women. There was no continuity of these serviees from in jail to out. A large majority of the women had children who were in foster eare, and they expressed the strong desire to have them back. *SJ* said he was going to have his assistant sit in with the group. *LO'C* said there was not a lot being done around eonfidentiality. *SJ* said they could dispel the situation by doing outreach to everyone. *DJ* expressed the need to figure out a more cost-effective utilization of money aeross the systems that works better on linkage. Asked if they were funding any eontraets that aetually went into the jails. *LT* responded that Forensic AIDS doesn't have the funding or the staffing to deal with everyone with HIV. *DJ* said that a lot of people were ehoosing not to deal with them, but that there needed to be an alternative. *LT* said that Forensie AIDS is linked into the Integrated Serviee Model. There was a need to improve this linkage. *SJ* questioned the effectiveness of the linkage. Asked why AIDS Forensie doesn't do more outreach. Need to de-mystify AIDS in the jail setting. *DJ* expressed the need for a jail summit. *LT* replied she was working on a SPINS Proposal. *SJ* expressed eoncern that AIDS Forensie was getting in on a collaboration of that kind having not proven they eould do the job. *DJ* said there was still the question of unmet need. Maybe the SPINS Grant addresses it and maybe it doesn't. *LT* warned about pulling money out of other services. Talk about the unmet need and the priorities and how to link it in, but wait a little bit before pulling money out. *LO'C* said that linkages cost money. *MS* said there was money set-aside for treatment on demand in the jails. ($200,000.) *DM* asked how many people in the jails who were using were being pulled out and direeted to mental health. *DJ* said she didn't think the CARE funded mental health workers were taking care of them. DM replied that sinee there wasn't anywhere for them to go they were probably being treated inappropriately. *SJ* talked about a client who decompensated right in the jail. They really don't get it inside there. AIDS Forensie just doesn't have time to deal with the aeute eases. *DJ* expressed the need to reeognize that the serviees funded in this serviee category are bouncing back and forth between the two systems. The question is where the best plaee was to serve them. MS asked if there were statistics on the CARE funded clients. *DJ* said she didn't know what happened in the implementation of last year's plan. *DM* said he'd report baek at a later time in response to specific questions. LT related what she knew. LO'C asked if there were new standards that eame out of the Harm Reduction Conference that would influence with how we work with contracts to modify them. *MS* said those had not been implemented. Just at the beginning stage of looking at that. *DJ* talked about the need for change in the system. *DM* replied that change in the system is incremental. Trying to implement continuity. *DJ* talked about doing a better job of implementation between CARE Council and AIDS Office. *MS* said the DPH has the right to tell providers they need to change. DM stated that to make a change you have to attaeh an award to that change. *MS* replied that the providers could be redirected in their efforts. *LO'C* discussed CARE.*DJ* asked for the changes made in last year's contracts. *DM* promised to report baek.